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INFORMED CONSENT FOR GENERAL DENTISTRY AND ANESTHESIA

State law requires us to obtain your consent to your contemplated treatment, surgery or dental-medical procedure. Please read the form carefully. Ask about anything you do not understand. We will be pleased to explain. What you are being asked to sign is a confirmation that you understand the nature and purpose of your contemplated treatment, surgery or dental-medical procedure and the risks associated with it.

It is my responsibility to discuss with Dr. Scott my past medical and health history including any serious problems and/or injuries.

I, the undersigned, hereby authorize and request Dr. L. King Scott and/or his associates to perform the following treatment/procedure/surgery on me:

1. General Dentistry — filling(s) (restorations), crown(s), bridge(s), root canal therapy and/or other.

A. Fillings:

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement.

B. Crowns and Bridges:

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc, of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return for final cementation of the restoration, I understand I may need further treatment by a specialist if complications arise during or after treatment, and any costs thus incurred are my responsibility.

C. Root Canal Therapy:

I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not effect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise. I understand I may need further treatment by a specialist if complications arise during or after treatment, and any costs thus incurred are my responsibility.

2. Periodontal Treatment

Periodontal Disease:

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, known as scaling and root planning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following Dr. Scott's and his associates' instruction, including strict observance of recall appointments. I understand that additional care by a specialist may be necessary.

3. Emergency Treatment

Drugs and Medications:

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions including death. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

Anesthetic Risks include:

Discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis), which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of anesthesia. Anesthesia is a medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

4. Single Tooth Extraction

Extractions:

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas,

cheek, tongue, gums and teeth, such numbness may be temporary or permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

5. Multiple Tooth Extraction

Taking teeth out is a permanent process. Whether the procedure is easy or difficult, it is still a surgical procedure. All surgeries have some risks. They include the following and others:

Swelling, bruising and pain.

Stretching of the corners of the mouth that may lead to cracking or bruising.

Possible infection that might need more treatment.

Dry socket - jaw pain beginning a few days after surgery, usually needing additional care.

Possible damage to other teeth close to the ones being taken out, more often those with large fillings or caps.

Numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may be permanent.

Trismus — you can only open your mouth a little. This is most common after wisdom teeth are taken out. Sometimes it happens because of jaw joint problems (TMJ), mainly when TMJ disease is already there.

Bleeding — oozing can often happen for several hours, but a lot of bleeding is not common.

Sharp ridges or bone splinters may form later at the edge of the hole where the tooth was taken out. These may need another surgery to smooth or remove.

Sometimes tooth roots may be left in to avoid harming important things such as nerves or a sinus (a hollow space above your upper back teeth).

The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment.

It is very rare that the jaw will break, but it is possible in cases where the teeth are buried very deep in their sockets.

I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

6. Extraction of Third Molars

All information presented on extractions and multiple extractions with special emphasis on: Numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may be permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

7. Incise and Drain-cut open and allow infection to ozze out.

8. Apicoectomy-a special type of root surgery associated with infected root canal therapy.

9. Treatment for Dry Socket (osteomylitis)- infection of the bone, usually associated with recent extractions.

10. Dentures:

I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months; I understand that failure to keep appointments may result in a less desirable result. If remake is required due to my delay, additional fees may be incurred.

11. Others: _____

12. I understand that further care by a dental/medical specialist may be needed if complications during or after treatment, and that costs incurred are my responsibility.

Changes in Treatment Plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize Dr. Scott to use professional judgment to provide appropriate care.

Alternative Treatment(s) Include:

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I authorize. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

Publication Of Records:

I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public without my permission.

General Information:

You have the right to be informed about your diagnosis and planned procedure/treatment/surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

I understand that the purpose of the procedure/treatment/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. I understand if this condition persists without treatment or surgery, my present condition will probably worsen in time, and the risks to my health may include, but are not limited to the following:

Swelling; pain; infection; cysts formation; periodontal (gum) diseases; dental caries; malocclusion; pathologic fracture of jaw; premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

I understand although good results are expected, the possibility and nature of all possible complications cannot be accurately anticipated and that, therefore, there can be no guarantee as to the results of the procedure/surgery.

I consent to the performance of the above procedures (1-12), as well as to the performance of such additional alternative procedure(s), as in the judgment of Dr. Scott, may be necessary to restore and/or preserve my overall dental health, as well as to treat the particular dental disorder(s) described to me.

I understand that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the procedure or as to cure.

Risks:

I understand there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such operative risks include, but are not limited to:

1. Drug Reaction — A reaction is possible for any medication given and could include nausea, rash, allergic reaction, anaphylactic shock and/or death.
2. Soreness at injection site may develop as well as some discoloration of the injection site or swelling.
3. Stretching of the corners of the mouth with resultant cracking and bruising.
4. Injury to adjacent teeth and fillings.
5. Swallowing and/or breakage of instruments.
6. Swallowing and/or breakage of materials, prosthesis, appliance, crown(s), bridge(s), temporary crown(s), and temporary bridge(s).
7. Restricted mouth opening for several days or weeks.
8. Post-operative discomfort/pain and swelling that may necessitate several days of home recuperation.
9. Heavy bleeding that may be prolonged.
10. Fracture of a root.
11. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
12. Breakage of the jaw.
13. Paresthesia (numbness) to jaw, face, neck.
14. Injury to the nerve underlining the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in other instances, permanently.
15. Opening of the sinuses (a normal cavity situated above the upper teeth) requiring additional surgery.
16. If intravenous medication is used, soreness/swelling at injection site along the vein may develop as well as some discoloration of the injection site.
17. Dry socket.
18. Post-operative infection, requiring additional treatment.
19. Initial bleeding, soreness, swelling and bruising.
20. Others:_____

Additional Authorization:

I also authorize and direct Dr. Scott with associates or assistants to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent, or services of the X-ray department or laboratories, and I hereby consent there to.

Some risks known to be associated with this procedure, including anesthesia are: Brain damage; quadriplegia (paralysis of all arms and legs); paraplegia (paralysis of both legs); loss of organ; loss of arm or leg; loss of function of organ; loss of function of arm or leg; disfiguring scars; death.

I consent to administration of anesthesia, including local, inhalation, oral, intravenous, and/or general anesthesia necessary for Dr. Scott (and/or his designated associates) to accomplish the proposed procedure.

I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires an anesthetic.

If any unforeseen condition should arise in the course of the operation calling for Dr. Scott's judgment or for procedures in addition to or different from those now contemplated, I request and authorize Dr. Scott to do whatever he may deem advisable.

SUMMARY:

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite care provided. However, it is Dr. Scott's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I agree to cooperate completely with the recommendations of Dr. Scott while I am under his care, realizing that any lack of same could result in a less than optimum result.

I consent to the taking and use of photographs, material, tissue, and records pertinent to my case in the advancement of dental teaching, research, demonstration, and the writing of articles for scientific publication.

ANESTHESIA:

LOCAL ANESTHESIA: A shot is given to block pain in the area to be worked on.

NITROUS OXIDE WITH LOCAL ANESTHESIA: Nitrous Oxide (or Laughing Gas) helps to lessen uncomfortable sensations and offers some relaxation.

ORAL PREMEDICATION WITH LOCAL ANESTHESIA: A pill is taken for relaxation prior to giving local anesthesia.

Whichever technique you choose, giving any medication involves certain risks. These include:
Nausea and vomiting.
An allergic or unexpected reaction. If an allergic reaction is severe, it might cause more serious breathing or heart problems, which may need treatment or may lead to heart attack, stroke or death.

In addition, there may be:
Pain, swelling, or infection of the area where the anesthesia or sedation was given.

1. Injury to nerves or blood vessels.
2. Confusion, or a long period of sleepiness after surgery
3. Heart or breathing responses, which may lead to heart attack, stroke, or death.

I understand the above and give my consent for:

- ❑ Local Anesthesia
- ❑ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
- ❑ Oral Premedication with Local Anesthesia
- ❑ General Anesthesia in Hospital/Surgery Center.

I understand that my doctor can't promise that everything will be perfect. I understand the above and give my consent to the treatment, surgery or dental-medical procedure. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, recreational drug use, vitamins, homeopathic medicines and remedies.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE TREATMENT AND THE EXPLANATION REFERRED TO OR MADE. I ALSO STATE I UNDERSTAND ENGLISH.

This consent form is valid until **revoked by me in writing.**

Signature of Patient:_____ **Date**_____

Print Name of Patient_____

Signature of Parent or Guardian _____

In the event of my failure to pay the balance in full within 30 days of the date services rendered, I agree to pay finance charges of 1 1/2% monthly (APR: 18%) on the unpaid balance.

Signature of Patient or Responsible Party _____ **Date**_____